LOS ANGELES COUNTY
COMMISSION ON HIV HEALTH SERVICES

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Signing-in constitutes public notice of attendance. Sign-in is not required by public attending the meeting, however comments on the record constitute signing-in. Otherwise, presence at meetings is recorded solely based on sign-in sheets. Not signing-in constitutes absence for Commission members.

Only members of Commission on HIV Health Services are accorded voting privileges. Commission members cannot vote who have not signed in.

Approved July 10, 2003

COMMISSION MEETING MINUTES
June 12, 2003

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT	OTHERS PRESENT *(cont.)*
Al Ballesteros, *Co-Chair*	John Caranto	Jeff Bailey	Stephen D. Simon
Nettie DeAugustine, *Co-Chair*	Richard Corian (E)	John E. Bantis	Jim Stewart
Adrian Aguilar	Nancy Eugenio	Cinderella Barrios-Cernik	Louise Trone
Carla Bailey	Rebecca Johnson-Heath	Jeff Berg	Juan Verdugo
Carrie Broadus	Mary Lucey	Robert Blue	James Ward
Robert Butler	Hernan Molina	Robert Bojoaquez	Nicole Werner
Genevieve Clavreul	Chris Perry	James Boyd	Sam Wilson
Richard Eastman	Alexis Rivera	Gordon Bunch	Jane Wise
Whitney Engeran	Paul Scott	Julie Coveney	Patricia Woody
Gunther Freehill	Vanessa Talamantes	Ruth M. Davis	
Danielle Glenn-Rivera (Alt)		Chris Edwards	
Alexander Gonzales		Steve Erickson	
Marc Haupert		Mark Etzel	
Charles Henry		William Fuentes	
Howard Jacobs		David Guigni	
Wilbert Jordan		Mavra Gonzalez	
Marcy Kaplan		Terry Grand	
Bradley Land/Dean Page (Alt)		John Griggs	
Mike Lewis	**OAPP STAFF PRESENT**	Juan Ibarra	
Anna Long	Libby Boyce	Miki Jackson	
Andrew Ma	Dean Goishi	Jennifer Karcher	
Elizabeth Marte	Carl Highshaw	Larry Lavias	
Edric Mendia	Jane Nachazel	Maxine Liggins	
Vicky Ortega	Gabriel Rodriguez	Luis Lopez	
John Palomo	Martha Teresa Ruiz	Jan Morrison	
Dana Pierce-Hedge	Rene Seidel	Demetri Moshoyannis	
Kevin Van Vreede	Anna Soto	Kym Murdock	
Fariba Younai	William Strain	Ane Purras	
Rodolfo Zamudio	Craig Vincent-Jones	Wendy Schwartz	

I. CALL TO ORDER: Ms. DeAugustine called the meeting to order at 9:40 a.m.

The meeting was opened in memory of Commissioner Michael White Bear Claws and the many contributions he had made in his life to PLWH. Condolences and support were expressed for his partner, Commissioner Richard Corian. The Board of Supervisors was being notified to request adjournment of their meeting in his memory.

II. APPROVAL OF AGENDA:
MOTION #1: Approve the Agenda without objection.

III. APPROVAL OF MEETING MINUTES:
MOTION #2: Approve the May 8, 2003 Commission meeting minutes without objection.

IV. PARLIAMENTARY TRAINING: Mr. Stewart, Parliamentarian, reminded the group that motions on the agenda were automatically made with approval of the agenda, and did not require seconds. "Committee of the Whole" is a mechanism for the normal sitting body, already having a quorum, to choose to address one or more specified issues in a less formal manner. The body adjourns into the "Committee of the Whole" for the discussions, then adjourns out of it to vote. There is no "Committee of the Whole" without a quorum.

V. PUBLIC COMMENT: Mr. Griggs thanked Commissioners who had come to the Antelope Valley help the Community Advisory Board there. People using the AV Hope Center had been told another health care foundation was planning to take over the Center and replace its staff, and they were opposed to the change. Mr. Lavias, Mr. Bojoaquez and Mr. Wilson spoke on the importance of the AV Hope Center in their lives.

Ms. Edwards cautioned the Commission on referring to something as a "mandate" when it is a "recommendation". She also claimed that it was misleading that Mr. Henry and Mr. Freehill were not specifically noted as non-voting on the Committee Assignment list. She also asserted that an unnamed Commissioner illegally lobbied at the last BOS meeting. Ms. Broadus responded, noting that all Commissioners were required to complete a Form 700 listing all interests and affiliations—which should detail when a Commissioner is lobbying versus performing their advisory duties.

VI. STANDING COMMITTEE REPORTS:
FINANCE
Staffing Pattern: Mr. Ma, Finance Co-Chair, introduced the Commission staffing pattern motion.

- Ms. DeAugustine noted the staffing pattern would not exceed the approved allocation for Year 13, and that there would be cost savings in personnel.
- Dr. Clavreul felt there were proportionately too many managers, especially in light of the use of consultants. Ms. DeAugustine replied that staff was targeted to reduce reliance on consultants. Levels were chosen to be fewer, but more flexible in meeting Commission needs.
- Mr. Jacobs asked if there were job descriptions. Ms. DeAugustine replied they were. He noted the Children and Families First Commission has 36 staff for 11 Commissioners. He felt staffing was too low, even more so if the Commission and PPC merged. Ms. DeAugustine replied that the merger was a separate issue. Regarding Commission staff, she said this plan was designed to form the core around which to thoughtfully build in future.
- Mr. Ballesteros noted that time would be taken to assure appropriate hires. Ms. DeAugustine added that Charlene Abe, Executive Office liaison, had given assurance that the Executive Committee and Commission would be involved in staffing decisions.
- Given that staffing was planned around tasks, Ms. Broadus expressed concern that there would be inadequate support for public policy staff. Ms. DeAugustine replied that public policy work was assigned to the Executive Director due to its importance.
- Mr. Henry voiced his support for the transition. He noted the Commission had been looking at the issue for at least five years, noting that this plan is more consistent with HRSA's policy guidance. This motion authorizes the Executive Office to place the plan and its budget before the BOS for approval with other budget measures at the end of June. Only after that approval could the Executive Office begin working with the Department of Human Resources to develop job descriptions consistent with approved job classifications. Mr. Henry felt that the staffing pattern was an important step to meet the HRSA expectations of development and maturity in this EMA, since it was one of the first 16 jurisdictions funded.
- Ms. DeAugustine noted the Executive Office would assist with support staff.
- All thanked Ms. Abe for her work on the project.

MOTION #3: Approve the revised Commission staffing pattern and budget proposed by the Executive Office of the Los Angeles County Board Of Supervisors ***(Passed: 19 ayes, 2 noes, 1 abstention)***

Mr. Ma noted that the Financial Reports were in packet. Title I had two delinquent agencies; Title II none.

STANDARDS OF CARE

Dental Standards Of Care: Dr. Younai, SOC Co-Chair, presented the "Practice Guidelines for the Treatment of HIV Patients in General Dentistry". Guidelines were developed, and recently revised by the Dental Steering Committee of the Pacific Region AIDS Education and Training Centers (AETC). Dr. Younai gave a PowerPoint presentation on the Standard:

- A cross-section of individuals in oral health care contributed.
- Other resources are available from the American Dental Association (1995), the Academy of Oral Health (2002) and a training course for the oral health professional produced by the U.S. Department of Health and Human Services (2001).
- CD4 count and viral load indicate the general health of the patient, but should not been used as a basis to withhold treatment.
- Dentists can play a major role in encouraging good health follow-up.
- Antibiotic prophylaxis is not routinely indicated for dental care. Cardiac issues may indicate their use in consultation with the patient's physician.
- Medical assessment is the standard of care, including laboratory data, if indicated. Used in consultation with patient's physician to determine whether care is best given in an office or hospital.
- Considerations for treatment planning include bleeding tendencies, patient ability to tolerate long or multiple visits, whether to use a pre-treatment antibacterial mouth rinse, whether to schedule three- or six-month routine appointments, whether there is reduced salivary function leading to potential lesions or other disease and/or whether fluoride supplements are needed for patients with increased caries or dry mouth.
- Early in the epidemic, PLWH routinely presented with oral yeast infections. PLWH who are not in treatment, who are noncompliant or whose treatment is failing commonly develop oral fungal infections and often more severe infections than would occur in seronegative patients. Prophylaxis, once universal, should be evaluated on a case-by-case basis.
- Patients are less commonly evaluated for periodontal disease, but disease of a severity to result in rapid bone loss with subsequent tooth loss can occur even in medically well-managed patients.
- Frequently seen viral infections are hairy leukoplakia (Epstein-Barr Virus), shingles of the mouth and/or facial tissue, herpes in the mouth and, with increasing prevalence, human papiloma virus (oral warts).
- Cancer sores may be located throughout the mouth.
- Kaposi sarcoma has become less common, but may occur in patients who have not been in treatment or whose treatment is failing. Other cancers like lymphoma or squamous cell cancer may also present orally.
- Significant oral disease often compromises nutrition due to discomfort in eating.
- Multiple studies in the last five years show a decline in most oral diseases, but a rise in oral warts, which can be contagious, and salivary gland diseases like oral dryness and cysts or cancers of salivary glands.
- Studies consistently correlate the prevalence of oral lesions with low CD4 count and high viral load.
- Most PLWH, including those who are symptomatic, can be treated in the office.
- It was asked if disposable instruments were commonly used for PLWH. Dr. Younai answered that today's best practice standard is to use disposable equipment, instruments and other materiel wherever possible with all patients. It meets infection control requirements more cost effectively with less wear-and-tear on instruments. It is recommended in the new CDC dental guidelines.
- Dentists and dental providers are legally required to refer a patient for HIV counseling and testing if the medical history or oral examination indicates the patient may be at risk.
- Referral to a specialist or hospital is legal only for patient clinical needs. Refusal to care for PLWH due to fear of infection violates the Americans with Disabilities Act, California law, the law of various local jurisdictions, and ethical standards of both the American and California Dental Associations.
- Post-exposure protocol in California provides dentists the right to request that a patient be tested for HIV if there has been any kind of exposure (such as needle stick, splash, puncture, bite, etc.). Patients may refuse.
- Dentists are responsible for training staff to ensure that all patient information is kept confidential in accordance with HIPAA and State law.

- An office atmosphere that assures confidentiality enhances patient trust in sharing sensitive medical information that will be needed to inform the best care.
- Infection control protocols are provided in the guidelines, including Hepatitus B vaccination, Hepatitus C exposure management and Post-Exposure Prophylaxis (PEP) for HIV exposure.
- The comparative risk of infection from blood-to-blood contact for HBV is 6% to 29%, for HCV is 1% to 3%, and for HIV is 0.2% to 0.3%.
- Nutritional counseling requires awareness and management of causes of inadequate nutrition. Causes may include economic challenges in obtaining proper food or discomfort in chewing and/or swallowing due to oral disease. Oral disease may also adversely affect smell and taste.
- Dentists should be aware of potential medication side effects. There are no known drug interactions between antiretrovirals and local anesthetics used in general dentistry.
- There are multiple websites where dentists may enhance and update their information.
- Ms. Kaplan asked if RWCA dental clinics offer better care. Dr. Younai replied that any provider who has experience with HIV+ patients, as in medical care, is more effective. Since Title I dedicated-clinics have financial restrictions similar to Denti-Cal, payment is for restoring partial function. So, for example, procedures like root canals on posterior teeth would not be approved. Reimbursement is at 48%. USC permits patients to pay for half of their care, allowing for a broader range of procedures.
- Mr. Henry asked if the guidelines recommended patient education on precautions regarding oral sexual activity following cleaning or invasive procedures. Dr. Younai replied that this guideline focused on the provider, but there was discussion of developing a patient guideline. General oral health education would, however, address some of those concerns and was in the guideline.
- Mr. Broadus asked how the standard would be disseminated. Dr. Younai replied that dissemination strategy for all the standards was being developed. The AETCs will also be using it in their training. Coordination between the Commission authority and the AETC provider training would be critical, in particular since a previous State law required an HIV update for bi-annual licensing.
- Mr. Henry recommended the presentation can also be provided to the PPC in order to support dental linkages for counseling and testing, where appropriate. Dr. Younai agreed that would be an important component since dentists are often unfamiliar with those resources.
- Ms. Kaplan asked if there were specific youth access issues in Los Angeles. Dr. Younai said there was no specific information on that, however, orthodontics, due to its expense, may not be adequately provided.

MOTION #4: "Practice Guidelines for the Treatment of HIV Patients in General Dentistry" was approved without objection.

Half-day Outcomes Training: A tentative date is being set in August for outcomes training in preparation for outcomes development activities.

Mr. Engeran asked for an update on the Patient Bill of Rights. Dr. Younai replied that a subcommittee was working on it. It was being expanded to include rights of both consumers and providers. Mr. Engeran said he would prefer the consumer rights component be addressed separately, but was most concerned that the document moves expeditiously. Ms. DeAugustine said a report would be brought back to the July meeting.

PRIORITIES AND PLANNING

Mr. Land noted that the Committee had been asked by the Commission to develop a presentation procedure. The Committee's process has resulted in a rough draft that is now being distributed to the other committees for review and feedback. The Committee planned to incorporate the feedback and bring the procedure to the Commission for adoption at the July meeting.

Mr. Land reported he and Mr. Haupert had sent out thank you letters to the consortia that provided feedback to the Comprehensive Care Plan presentations of the last year. The packet included copies of the letters.

Commission Directive Form: Mr. Haupert noted that the manner in which priorities and new service areas were communicated needed to be enhanced. The proposed "Directive To Take Action" was developed to ensure accurate communication among the Administrative Agency, the Grantee, the Commission and its committees.

- The form is in data format. Gray areas expand to accommodate whatever comments are needed.
- The form details, rather than supercedes, the motion on an item.
- The form outlines what the directive is; to whom it is targeted; the impacted area or population; its source of funding; the type of impact intended, like service delivery or cost effectiveness; its nature, whether a new item or improvement; outcomes desired; the justification; steps in directive development; comparison to current activities; and any other specific instructions.
- Mr. Henry suggested the Commission look at developing one form format for use by all committees for consistency. Ms. Broadus suggested that all committees review this form and offer suggestions for incorporation into a final version to be utilized by all committees.
- Mr. Stewart noted the form had been approved for P&P use with the adviso that it be sent to all other committees for comment. Suggestions could be incorporated for a general form to be approved by the Commission the next month or the month after.

MOTION #5: "Directive To Take Action" was approved without objection.

Client Advocacy Directive: Mr. Haupert said the directive form was used to frame the client advocacy directive from last year. He said it incorporated the actions and intentions from last summer, while keeping in mind the realities of this year's budget. An additional document addressed client advocacy definitions in order to complement the new priority.

- The directive is targeted to the Commission, with system-wide impact on service delivery of client advocacy.
- The purpose of the directive is to assist clients in accessing both CARE Act and non-CARE Act services.
- The current definition uses client advocacy as extra CARE Act-funded services, but Mr. Haupert said the P&P Committee would like to expand that slightly to include some CARE Act-funded services.
- The directive would provide assistance to the SPA-based networks in resource identification. Such networks are required to identify resources, especially non-CARE Act-funded resources, in the SPAs.
- APLA is the current contractor to develop and maintain the HIV/LA Resource Directory.
- It is hoped that the HIV/LA Resource Directory and individual SPA activities would become more integrated.
- A consumer guide to educate clients in navigating the system is also envisioned.
- The justification is that the consumer needs assessment identified a significant and growing unmet need in core services, such as housing, transportation and food.
- While CARE Act resources are insufficient to impact all the identified needs directly, assisting consumers to locate resources would help ameliorate the problem.
- Meetings were held between January and May with committees and with Mr. Henry and his staff.
- The process also demonstrated that it required about two years from identifying a new priority to funding the service. This directive purposely blends into existing services to begin service as quickly as possible.
- Mr. Haupert noted other service categories include aspects of client advocacy, for example, case management; treatment advocacy, which has shifted more to adherence in the last few years; peer support; legal services; permanency planning; mental health; and referral services.
- Various health-related systems also include some form of client advocacy, such as ombudsman.
- This directive would expand the scope of currently contracted services to include technical assistance to SPA-based provider networks and the development a consumer guide.
- SOC is also requested to establish service effectiveness standards with OAPP's Quality Management Program.
- Ms. Broadus was concerned about how the directive would strengthen providers in their unfunded mandate to develop consumer advisory boards (CABs) and addressing client advocacy at their sites. Mr. Haupert replied that he was unaware of the unfunded mandates. Language could be expanded to ensure the goal is to blend funding into existing services, including those of providers and other bodies.
- Ms. Broadus also expressed concern that the directive was disconnected from related material in the Comprehensive Care Plan. Mr. Haupert responded that closing the very gap discussed earlier through available categories was the purpose of the directive.

- Mr. Ballesteros asked how the clients would access the network information. Mr. Haupert responded that the contractor would need to propose how they would implement it in their contract with OAPP.
- Mr. Jacobs asked if all agencies were required to have a CAB. Mr. Haupert replied that it was in all contracts.
- Mr. Page felt suggested that "advocacy" has an alternate meaning. Mr. Haupert agreed that different people use the term differently, but noted that this is the HRSA definition.
- Mr. Henry thanked P&P for its assistance in clarifying this service category for OAPP. He added that contractors were ethically expected to assess and refer clients to necessary services. Contractors receive significant funding for staff to ensure that all mandates are met, so there were no truly unfunded mandates. This directive expands the range of tools available to clients in meeting their needs. He said there was nothing inconsistent in this directive with the requirements for the service provider networks to assess and make services accessible their clients.
- Mr. Haupert noted that P&P would do additional work on the client advocacy definition in order to assist OAPP with RFP preparation for the next cycle. This cycle could not use the RFP process because there was insufficient time. The directive would act as a pilot to initiate the service category in the meantime.
- Ms. Broadus said fully functioning CABs for women required space, food, transportation and sometimes a stipend, adding that she considered the gap from the lack of funding an unfunded mandate. Ms. Broadus felt there had been enough time for an RFP, so client advocacy work did not need to be secured through a sole source. For those reasons, she said she would abstain.

MOTION #6: Approve the Client Advocacy Directive ***(Passed: 16 ayes, 1 no, 6 abstentions*)**.

Comprehensive Care Plan Revision Timeline: Mr. Land said it was necessary to revise the timeline in order to involve the planning consultant. The consultant, Partnership for Community Health, would be authorized to start July 1st.

- Purchase orders for design and printing would be done in July.
- Revisions would be developed from July through September 2003 working in conjunction with PCH, various committees and OAPP. Targeted revisions are: consolidate/incorporate community comments, incorporate Financial Needs Assessment, incorporate Patients' Bill of Rights, incorporate grievance procedures, integrate Quality Management section into Plan, revise "How Do We Monitor…" section with revision of outcomes/ ndicators, review goals and objectives with consistent format/language, and their consolidation into Plan.
- Mr. Land anticipated a draft by August, with the full Plan approved by the P&P and presented to the Commission in September 2003.
- This timeline would target Executive Committee and Commission approval by October so that the Plan could be included with the application.
- The design would be completed in November 2003 with printing scheduled for December.
- Plan dissemination would begin in January 2004. Mr. Land emphasized it was important to ensure that the material was disseminated in such a way as to ensure it was accessible by the average person.
- The revised timeline was being presented as a motion since it revises the P&P Work Plan.
- Ms. Broadus reported that the 2nd District Coalition feedback on the Plan indicated that there had not been sufficient community input. A time period should be identified for community feedback. Commission presentation and Public Comment was not sufficient. Mr. Haupert said an integral element of the Plan was continuous data collection. Part of the dissemination work should be to educate the community about their opportunities to formulate input and how such input would be processed at the Commission level.
- Ms. Broadus recommended that the P&P Committee develop a mechanism to disseminate documents and receive comments before the Commission votes final approval. While there might be insufficient time to engage a full process for this revision, the mechanism should be developed for the future.
- Dr. Clavreul said community representation was poor. Some focus groups, for example, only had 4 or 5 people. She reiterated that she had asked Mr. Land to give her prior notification of his presentations, but he did not.
- Mr. Henry noted there was a variety of important data sources, including community feedback, that is documented in the application. He felt a better job had traditionally been done collecting data, rather than analyzing it. The Plan is for it to be a living document with continuous data input, but that should include documented need and cost projections, as well as expressed need. He added that the enhancement of professional staff

support would address many issues where everyone agreed more could be done. He noted that he often traveled in the County and synthesized feedback he received for the Commission, as would be of value from all Commissioners.

- Mr. Engeran stated that, as a representative body, each Commissioner should be responsible to reflect his/her constituents' views and concerns.

MOTION #7: Comprehensive Care Plan Revision Timeline was approved without objection.

Mr. Land noted the "Second Generation Needs Assessment Topics" spreadsheet in the packet was a tool being presented for the Commission's information. It includes a list of acronyms.

RECRUITMENT, DIVERSITY AND BYLAWS

Mr. Butler noted that there were still some questions being resolved between the Commission and the Executive Office of the Board on which seats would term out at the end of June.

Evaluation of Commission Nominees: The "CHHS Nominee Evaluation" scoring sheet was included the packet. It would remain the basis for scoring applications, though periodically would be revised to meet shifting needs.

- The first criteria (30 points) is to meet legislated "unaffiliated" consumer compliance of 33%. That includes not being affiliated with or have fiduciary responsibility (like a board member) for any Title I grantee.
- Skill sets (10 points) include communication and planning.
- Experience (15 points) includes practical HIV/AODS experience in the arenas of service delivery, the Commission, public policy and/or volunteerism. Volunteer experience is specifically given 5 points this year to emphasize that this is a working Commission.
- Effective representation of proposed population (10 points) refers to the ability to communicate needs, interests and opportunities of the Commission and the constituency.
- Demographic representation (20 points) has been included to meet the legislated requirement that the EMA reflect the demographics of the local epidemic.
- Recommendations/verifications (10 points) including letters from nominating bodies.
- HIV/AIDS knowledge (5 points) that might be personal and/or professional.

MOTION #8: The "CHHS Nominee Evaluation" was approved without objection.

Unaffiliated Consumer Compliance Seat Assessment: Mr. Gonzales called attention to the assessment that RD&B had developed, necessary to evaluate the feasibility when attempting to fill a seat with an unaffiliated consumer. While some seats can be expected to be filled by members who are unaffiliated consumers, it is unlikely that some seats, such as the institutional ones, like Medi-Cal will ever be able to meet that goal.

- Mr. Butler emphasized that of 49 seats available, 40 seats are expected or strongly hoped to be compliant with the requirement.
- Mr. Freehill asked why some task force seats were assessed as "expected" and others were assessed as "possible". Mr. Butler responded that some task forces have a heavily professional membership. The Mental Health Task Force, for example, consists primarily of professionals, most of whom work for Title I-funded agencies. In those cases, while an unaffiliated consumer candidate might be desirable, it is not always possible. Ms. DeAugustine added that some seats are unusually hard to fill.
- Ms. Broadus asked if the assessment levels were mandated. Committee members responded that they are simply guidelines to help in the recruitment and nominations process.

JOINT PUBLIC POLICY

Mr. Engeran reported that representatives from Los Angeles Homeless Services Authority (LAHS), would report to the Committee on the matter raised earlier at the Commission. Rick Velasquez, from LA Cares, has been invited to speak on pending State legislation. An invitation to sit on the Committee has been extended to the Vice-Chair of LACHAC to increase collaboration and information exchange.

JPP is developing an action form similar to the directive form presented earlier by P&P. It is designed both to capture and track the movement of issues through JPP, as well as to provide a means for other committees to refer matters to JPP.

There will be an election for the JPP Commission Co-Chair at next Friday's meeting due to the resignation of Hernan Molina as Co-Chair. Ms. Broadus said that while she had been nominated for the Co-Chair seat, she was withdrawing and supporting Mr. Engeran for the position.

VIII. **STATE OFFICE OF AIDS**: Returning from a meeting of all of the large ADAP programs in Washington, she Ms. Pierce-Hedge reported that all the states are having problems similar to California's. In reference to ADAP:

- A number of states have waiting lists.
- The Office of AIDS has also put forward language for a statute permitting a waiting list in California. While the Office does not want a waiting list, it was important to have options to manage the situation should funding fall short, rather than cutting the program off abruptly.
- Some states have added Fuzeon and have found it less of a budgetary problem than anticipated, probably due to stringent qualification requirements.
- The Senate and Assembly have gone to conference committee on the co-pay proposal. Ms. Pierce-Hedge said that while the original co-pays proposed were high, the $5/$10/$15 proposal would only save about $1.2M or $1.4M of the original proposal's $7.2M. As neither house is please with the co-pays, she felt it was likely that the co-pays were now off the table.
- Michael Montgomery, Director of the California Office of AIDS, and the pricing coalition have been negotiating with the ten largest drug companies. To date, there has been some positive feedback from seven of the ten companies, including additional rebates and price breaks.

Ms. Pierce-Hedge noted that there had been a consortia meeting of the housing program, and that Peg Taylor, of her staff, has been heavily involved in the task force set up by the Governor to better leverage those kinds of funds. The high level of people participating has helped bring people to the table to discuss ways of working together in the State. A plan has been developed, and Ms. Pierce-Hedge said she would provide more information about it at the next meeting.

Ms. Pierce-Hedge announced that her new manger for Community Based Care is Jim Zuber. She suggested at a recent directors' meeting that they advise her office of issues or matters that might be reviewed. The dialogue resulted in a task force—including both program directors and fiscal agents—that has begun to meet. It is looking at things like reports and protocols that could be streamlined to reduce required staff time while still providing the State with necessary information.

She reiterated that some people had been looking at viral load resistance testing to cut, and that it is not statutorily mandated. The State Office of AIDS has been trying to hold harmless the program since programs that are not mandated are difficult to get back once they are cut.

- The Office is also attempting to put a therapeutic monitoring program in statute through the Senate. However, even if successful, it would require a trailer bill to fund it.
- Previously $8M was budgeted for these programs. She had heard funding estimates as low as $1M.
- Due to the uncertain funding, a letter was sent to all agencies advising them that vouchers would not be issued at this point in time.
- It will be a moving target until the budget is signed. She added that multiple scenarios were being developed on how to handle the situation under different funding possibilities.
- Mr. Jacobs asked how to ensure that rebate monies return to the ADAP rather than to the General Fund. She responded that ADAP was a dedicated fund through legislative statue. The Department of Finance grants spending authority to ensure that that money is part of the base for the drug program.

- Mr. Page asked if all viral load testing was suspended or if suspension applied only to ADAP clients. Ms. Pierce-Hedge clarified that the viral load testing suspended was the State Office of AIDS voucher program for ADAP clients.
- Mr. Freehill understood that Senate language for the therapeutic monitoring statute also gives the Director of the State Office of AIDS authority to move that funding into ADAP if the latter is underfunded. He added it was important to ensure all the needed programs stay in place and work together.
- Mr. Henry said Los Angeles used about 7,000 viral load and viral resistance vouchers. They are extremely important to medical outpatient providers. The tests are needed to prescribe and manage medications well, even more so with the advent of Fuzeon. The voucher program should be defended as staunchly as ADAP.

Mr. Freehill reported that the expected 15% reduction in Medi-Cal reimbursement had been rolled back. There would be no reduction in reimbursements to providers. While that did not directly affect Title I services, it did impact the ability of larger providers to maintain the cash flow to keep services in place.

- Mr. Jacobs said he had heard that physician reimbursements were still on the table, but that the optional Medi-Cal benefits would be reinstated.
- Mr. Henry said both the reimbursement rates and optional benefits were maintained.
- Ms. Pierce-Hedge said she was not as informed about Medi-Cal, but she had been in a meeting with Peter Mackler from the Director's office. He reported that President Bush had addressed the issue, and that Medi-Cal would be receiving about $40 million. There had not been a final determination on how it would be applied, though she thought 14 of the 17 optional benefits had been kept.
- Mr. Freehill noted that Denti-Cal had been cut and there was no indication that it would be restored.

He offered a reminder that the Governor of California had the authority to make changes to the budget right until it is implemented. In the last week or two budget discussions were increasingly being held behind closed doors. It was important to keep careful watch on the process.

Mr. Jacobs asked what would happen if there was no budget. Ms. Pierce-Hedge responded there was funding for State Office of AIDS programs through September 1st. They have been able to issue contracts with that proviso.

IX. CO-CHAIRS' REPORT

Planning Body Membership Recommendations: Ms. DeAugustine introduced Jeff Bailey, PPC Co-Chair, and Mark Etzel, PPC Co-Chair Designee, to report with Mr. Ballesteros and her on the recommendations originally developed by the Planning Body Structure and Membership Task Force of the Strategic Planning Process. The Task Force was composed of the core planning partners: the Commission, the PPC, the OAPP, and the Board Of Supervisors. This presentation was developed by the Commission and PPC Executive Committees and would be jointly presented to both bodies prior to their voting on the recommendations.

Mr. Bailey noted that the PPC had heard the presentation the previous week. The purpose of the presentations was to review the Strategic Planning Process and its recommendations, review current Commission and PPC planning body structures, and present action items for consideration. He introduced a PowerPoint presentation that began with background on the recommendations:

- As the epidemic changes, the bodies require a process to keep service planning current.
- In addition to the core planning partners, Commission and PPC members met with Health Deputies and individually with the offices of various supervisors.
- Dr. John Schunhoff had been invited to both the Commission and PPC presentations, but was unable to attend. DHS has also been discussing the structure of the bodies.
- Outcomes desired are that HIV planning be community responsive and relevant, to strengthen Core Planning Partner infrastructure, and to develop structures for the integration of HIV prevention and care services.
- The charge of the Task Force was to review current body structures as well as pertinent federal guidance documents and technical assistance papers.

Ms. DeAugustine continued the presentation with the key points reviewed by the Task Force:

- HIV planning must be driven by health outcomes.
- Attention must be paid to parity, inclusion and representation.
- Prevention and care/treatment perspectives needed to be integrated for the best outcomes.
- It is critical to maintain a good balance between prevention and care/treatment.
- Recommendations are subject to approval, in whole or in part by the bodies, as well as any and all revisions.
- Recommendation #1: Single, merged, planning body of 25 members instead of a separate Commission (49 members) and PPC (33 members). Committees were anticipated to draw additional participants to contribute to work development.
- Recommendation #2: Create and financially support a sustainable way for communities and populations to communicate with planning body members.
- Recommendation #3: Charge planning body with recommending research-proven, community responsive and relevant services.
- Recommendation #4: Planning body required to demonstrate integrated prevention and care/treatment perspectives in its work products.
- Recommendations #5: Planning body to have responsibility for all relevant HIV funds distributed through OAPP, including CARE Act, CDC, State and Net County Cost (NCC) funds. NCC funds are currently not overseen by either the Commission or the PPC.
- Recommendation # 6: Implement professionally staffed membership management program to enhance membership participation.
- Recommendation #7: Appoint a transition team so that a plan would be developed no later than the June 2004 Commission Ordinance Sunset Review.
- The PPC is established by guidance of the CDC to advise OAPP on HIV prevention.
- The PPC has 33 members recommended by the PPC, seated by OAPP and composed to achieve parity, inclusion and representation of the community.
- The PPC's primary work product is the annual HIV Prevention Plan.
- The Commission is established by the Ryan White CARE Act with oversight by HRSA to provide planning, resource allocation and evaluation to advise the Board of Supervisors on HIV care/treatment.
- The Commission has 49 members nominated and appointed by the Board of Supervisors with composition designated by the CARE Act, the Board of Supervisors and the County.
- The Commission's primary work products are the Comprehensive Care Plan and the Standards of Care.
- Five other large EMAs and the State of California were reviewed for comparison of their planning body structures. San Francisco, Houston, Chicago, Philadelphia and New York all have separate prevention and care/treatment bodies. The State of California has had both separate and merged bodies at various times. The State is currently in a transition process.

Mr. Etzel explained that both the PPC and Commission would hear the same presentation and address the same action items. The joint meetings of the two Executive Committees felt it was important for both parties to have time to consider and discuss the same items in order to achieve a consensus on items. The items would not come up for vote until the July meeting.

- Action Item #1: Does the planning body endorse the concept of a single planning body in Los Angeles County responsible for planning and evaluating HIV prevention and care/treatment services?
- While the Task Force made 7 recommendations, it was decided at the joint meetings of the two Executive Committees that the primary recommendation to be decided was whether or not the bodies should merge.
- Action Item #2: If the planning body does not endorse the concept of a single planning body, should the HIV planning structure include two independent and equal planning bodies – one for prevention and one for care/treatment?
- It is important to be aware of the distinctions addressed earlier between the two current bodies regarding their authorization, to whom they report, and how seats are defined. For example, even though Mr. Etzel is JPP Co-Chair, he pointed out he could not vote because of the difference in appointment structures.

- Is a single planning body feasible?
- The Task Force recommendation calls not only for a single planning body, but for a smaller one. Is that practical with the amount of work involved?
- Is it reasonable for a smaller planning body to use the committee structure to increase the number of participants and perspectives in the planning process?
- Is it realistic for a single planning body to produce both the prevention and care/treatment plans while meeting other CDC and HRSA requirements?
- The PPC and Commission need to address these issues now to ensure their leadership on issues pertaining to the structure and composition of the planning bod(ies). That includes providing direction to the multi-department County work group convened to address the question in response to a Board motion. That also includes recommendations pertinent to the 2004 Commission Ordinance Sunset Review.

Mr. Ballesteros presented the next steps developed for consideration of the action items:

- There will be a joint meeting of the two Executive Committees on June 19th to review feedback from the Commission and PPC meetings
- The action items will be returned to the two bodies at their July meetings.
- Representatives from the Commission and PPC will meet with DHS in August to express the recommendations of the planning bodies.
- JPP will schedule meetings in September to express the planning bodies' recommendations to the Health Deputies.
- PPC and Commission representatives will provide input to DHS, the Board Health Deputies and County counsel on language for the Ordinance in October 2003.
- The planning bodies will be continuously updated at their regular meetings.
- Mr. Jacobs asked what the multi-department work group was developing. The Co-Chairs had not been informed, though they had attempted to contact Dr. Schunhoff. Mr. Etzel noted that, while the work group was established in response to a Board motion, there were no PPC or Commission representatives on it. Mr. Engeran said he also e-mailed Dr. Schunhoff.
- He asked if OAPP was involved in the work group or had perspectives. Mr. Henry said OAPP replied that OAPP was not, and he was only aware of some informal discussions between DHS management and the CAO, though OAPP staff had contributed research on the size of CARE Act planning bodies in other EMAs.
- Mr. Henry felt the Board motion was more focused on the CARE Act planning body structure than on a potential merger of the two bodies.
- Mr. Etzel contributed that, while the Board motion focused on the CARE Act planning body, prevention was also strongly emphasized in a March meeting he attended with Dr. Thomas Garthwaite, Director of DHS, and the two bodies' Co-Chairs.
- Ms. Broadus asked how a merged body would meet CARE Act requirements, for example, the mandate for 33% unaffiliated consumers. Ms. DeAugustine said the PPC is also mandated to be representative. Mr. Henry said the CDC has a PIR requirement that included, but was not exclusive to, PLWH. While there would be practical implementation challenges, no legislative or CDC guidelines could be abrogated.
- Ms. Broadus felt JPP should be integrated into the activity earlier than in September. Mr. Etzel noted communication with the Health Deputies was already occurring, as witnessed by the letter and copy of the action plan sent to them in May by the two bodies' Co-Chairs. The September Health Deputy presentation is planned to synthesize the work of the two bodies that will have taken place by that time.
- Dr. Jordan noted there were no major EMAs listed that have joint planning bodies. He asked if there were any. Mr. Henry replied that most areas have separate jurisdictions for the CARE Act and the CDC. Only the UCHAP EMAs, of which Los Angeles is one, have both. The other five are the ones listed earlier and all have separate bodies for prevention and care/treatment. Mr. Goishi commented that the other five do all have cross-fertilization between their two planning bodies. Dr. Jordan felt the option of more cross-fertilization should be specifically presented as a possible action item.
- Dr. Jordan said he was concerned that a smaller body would increase the workload on individual members. That could result in undue stress for PLWH. Meanwhile, he felt the Commission could do a better job in assisting Commissioners to reach out to and communicate with the constituents their seats represent.

- Mr. Butler advised that the Ordinance currently defines the PPC as a Select Committee of the Commission. He reflected that the political reality is generally based on the language in their Ordinances. Regardless of how the bodies choose to proceed, it should be considered that others are likely to be viewing the structure of the bodies in a markedly different light than the bodies view it.
- Mr. Engeran suggested a letter to Dr. Garthwaite requesting his attendance at the July meeting. Mr. Henry said it was important to be aware that DHS was not the sole focus of the Board motion. County Counsel has to draft any Ordinance. The CAO initiated the DHS conversations. The Executive Office was now involved due to the upcoming move of the Commission's support staff there. Mr. Henry said there should be communication with all those involved. Ms. DeAugustine noted that Dr. Schunhoff had reported that he would coordinate the effort with Dr. Garthwaite, so the Co-Chairs would communicate with him as well.

MOTION #9: It was approved without objection that the Commission Co-Chairs would strongly assert to DHS that the Commission and PPC need to be involved in the multi-department work group on planning body structure.

MOTION #10: It being 1:30 p.m., it was approved without objection to extend the meeting by 15 minutes.

Executive Committee At-Large Election: Ms. DeAugustine reminded the Commission that given Tom West's resignation from the Commission, there was an opening for an At-Large Member of the Executive Committee. Nominations were open through the next meeting, and could be proposed to the Co-Chairs or Mr. Vincent-Jones.

- Ms. DeAugustine nominated Howard Jacobs.
- Mr. Gonzales nominated Danielle Glenn-Rivera. Mr. Vincent-Jones noted that, as an alternate, Ms. Glenn-Rivera was not eligible for the seat.
- Mr. Land nominated John Palomo.

COA C3 Allocations/Endorsement Letter: Ms. DeAugustine called attention to the letter, provided in the packet for informational purposes. It verifies that allocations were made consistent with the final Year 13 Title I award and fulfills Condition of Award (COA) C3.

Minute-Taking: Ms. DeAugustine called attention to the memorandum in the packet and asked Mr. Vincent-Jones to summarize the proposed changes.

- Staff previously received feedback from HRSA that the minutes were an important educational tool both for HRSA and for community members who can only rarely attend meetings. The details provided information they would not normally receive.
- Staff also observed that shorter minutes often sparked questions about dialogue from certain Commission and community members. Material often had to be expanded after the fact.
- HRSA recently relayed, however, that the amount of detail provided was not necessary and did not seem cost effective.
- The proposed procedure would limit minutes to summaries of major points, key discourses and all significant decisions (including motions, votes and roll calls).
- Should individuals have questions about interpretations or discussions, the tapes will remain available and a transcription of the section can be done if necessary.
- The Executive Office of the Board has also agreed to arrange a standing purchase order with a transcription service so that an entire meeting could be transcribed if there is significant concern related to a specific item.
- Ms. DeAugustine noted transcriptions would be available at cost.
- Mr. Vincent-Jones said the change would permit significant staff time to be reallocated to other needs.
- Dr. Clavreul said accuracy, not length, was most important. She felt the minutes lacked accuracy.

MOTION #11: Approve the proposed "minute-taking" recommendations ***(Passed: 18 ayes, 2 noes, 3 abstentions)***

MOTION #12: It was approved without objection to extend the meeting by a second 15 minutes.

X. **OAPP REPORT**: Mr. Henry reported that RFPs for five CARE Act-funded service categories would be released in June and July. Child Care and Legal Services were most likely to be released in June.

- Food Services, Language and Translation Services, and Peer Support would be released in July.
- All were included in the Board Report.
- Their release sequence is dependent on the review of other offices, such as County Counsel.
- Providers will have five or six weeks to develop and submit proposals.

OAPP has been successful in having the Auditor-Controller engage a contractor, The Mercer Group, to do a rate review for Substance Abuse and Residential Services. This work is also consistent with the Board Report.

- The process will take place over several months.
- There will be stakeholder interviews.
- Data will be gathered on national, state and local standards for cost of services.
- Mr. Henry reported that, in his entrance conference with The Mercer Group and the Auditor-Controller, it was assured that at some point they would provide a presentation for the Commission of their final report, their recommendations and documentation of their process.

OAPP continued to work with the Auditor-Controller to release the RFP to identify a contractor to conduct rate review and development for the Medical Outpatient contracts.

In conjunction with the PPC and the Center for HIV Identification, Prevention and Treatment Services (CHIPTS), OAPP is co-sponsoring with the CDC the MSM Of Color Symposium on the coming Monday and Tuesday.

- Providers and planning bodies have been notified.
- Additional information is available through Ernesto Hinojos, Director, OAPP Educational Services.
- There are breakout groups by racial/ethnic population for both MSM and MSM/W targeted programs.
- Christopher Bates, Director, AIDS Office at U.S. DHHS is the luncheon speaker.
- Victor Barns, CDC, will also speak.
- Researchers specializing in prevention for these populations will be presenting.

Copies of the recently released social marketing materials were available at the resources table. There has been positive feedback from the community and the planning partners.

In response to last month's concerns about a potential change in staffing for the Antelope Valley Hope Clinic, Mr. Henry reported that there had been an inquiry by a community medical outpatient provider suggesting that they could provide care more cost effectively than the County.

- DHS Chief of Operations, Fred Leaf, directed the Finance Director, Gary Wells, to do a review of whether or not the community provider could offer more cost-effective care.
- The review should be completed by the end of June.
- High Desert Hospital remains slated for conversion to a multi-purpose ambulatory care clinic.
- Mr. Jacobs asked how those using the clinic might best register their opposition to the change. Mr. Henry recommended they put their thoughts in writing for both DHS and the Board of Supervisors. Ressie Roman, 5th District Health Deputy, especially, had indicated an interest.
- Mr. Henry felt the proportion of funding allocated to County versus community-based HIV clinics was a pertinent planning subject for the Commission to evaluate. The Co-Chairs agreed to review the subject.

In reference to the EMA Allocation, Spending spreadsheet in the packet, Mr. Henry noted The Virginian-Pilot of Norfolk, Virginia did an analysis of EMA expenditure of funds. Norfolk has been having some administrative agency difficulties, including under-utilization of funds. Los Angeles is one of five EMAs that fully expend funds. Mr. Henry noted that it demonstrated the effectiveness of the joint work of OAPP and the Commission.

- That would make it difficult for the Los Angeles EMA and the Orange EMA that also expended 100% of its funds to compensate for potential State viral load testing cutbacks.
- If Los Angeles and/or Orange did make difficult reallocations to fund viral load testing, that would eliminate a statewide standard of care since many areas do not receive Title I funds.

XI. **HIV EPIDEMIOLOGY REPORT**: There was no HIV Epidemiology report.

XII. **SELECT COMMITTEE ON PREVENTION PLANNING REPORT**: Mr. Mendia reported the PPC had rescheduled its regular meeting from July 3rd to July 15th due to the holiday.

The PPC voted to develop an addendum to last year's Prevention Plan in lieu of developing a full Plan this year.

- Mr. Mendia noted that DHS never approved funding for the PPC Annual Retreat at which the Prevention Plan was to be developed. For that and other reasons, it would not be possible to finish the planned work this year.
- An addendum would be incorporated into next year's Plan.
- Addendum copies were available at the resource table. Ms. Broadus asked when the coordinated prevention network contracts were going to be renewed. Mr. Mendia answered December 31, 2004.
- Referring to the PPC Executive Committee Summary of May 1, 2003, Ms. Broadus said the Addendum discussion referred to the issue of STD and HIV integration, and also to Hepatitis co-morbidity screening and vaccination. No mention was made, however, of the existing CDC-funded demonstration project regarding the coordinated prevention of HIV, STDs, TB and Hepatitis. She is concerned the demonstration projects will end and, unless they are incorporated into the Plan, funding will expire.
- Mr. Goishi responded that the details of the Addendum, as well as more plan information, was not yet available due to the cancellation of the retreat. Details would be developed at the special meetings. There had already been discussions on participation with the CPNs in data gathering.
- It was voted to hold two special meetings to partially compensate for the cancelled retreat.
- Ms. Broadus felt the demonstration projects should be folded into the Addendum and Plan. She recommended CPNs be invited to the planning meetings.
  It was also voted to hold two special meetings to partially compensate for the cancelled retreat.

XIII. **ANNOUNCEMENTS**: Ms. DeAugustine advised that the July meeting would need to be extended. There might also be a need for two July meetings. Items that needed to be discussed were priorities and allocations, needs assessment, financial needs assessment, assessment of the administrative mechanism, and membership and structure. The exact time would be provided later.

Mr. Land noted that earlier in the year there had been several flattering articles in the San Gabriel Valley about Dr. Clavreul. As he understood she was returning to nursing, and he acknowledged prior involvement with the Commission. She said she was glad to leave the Commission, and noted that she had found it purgatory. She added that she felt the process was totally flawed.

Mr. Eastman reported the State Senate had approved the Vasconsuellos Bill authorizing medical marijuana ID cards. It still had to pass the Assembly and be signed by the Governor. He encouraged support. He added that the Medical Marijuana Task Force would be meeting on August 2, 2003 from noon to 6:00 p.m. at the Hollywood Ramada Inn.

Mr. Page reported that the monthly LA County HIV/AIDS Advocacy meeting was the following day. They recently had a victory in reinstating food through two providers, he added.

XIV. **ADJOURNMENT**: Ms. Glenn-Rivera reported that Richard Corian had told her that Michael White Bear Claws had appreciated the time he had spent on the Commission. He loved the work, especially with the Finance Committee. The meeting adjourned in memory of Michael White Bear Claws at 2:00 p.m.

MOTION AND VOTING SUMMARY		
MOTION #1: Approve Agenda	***Without objection***	**Motion Passes**
MOTION #2: Approve May 8, 2003 Meeting Minutes	***Without objection***	**Motion Passes**
MOTION #3: Approve staffing pattern and budget	**Ayes:** *Broadus, Butler, Eastman, Engeran, Gonzales, Haupert, Kaplan, Land, Long, Ma, Marte, Mendia, Ortega, Palomo, Van Vreede, Younai, Zamudio, Ballesteros, DeAugustine* **Opposed:** *Clavreul, Jacobs* **Abstentions:** *Pierce-Hedge*	**Motion Passes:** 19 ayes, 2 opposed, 1 abstention
MOTION #4: Approve "Practice Guidelines for the Treatment of HIV Patients in General Dentistry"	***Without objection***	**Motion Passes**
MOTION #5: Approve "Directive To Take Action"	***Without objection***	**Motion Passes**
MOTION #6: Approve Client Advocacy Directive	**Ayes:** *Bailey, Butler, Clavreul, Eastman, Glenn-Rivera, Gonzales, Haupert, Land, Long, Ma, Palomo, Van Vreede, Younai, Zamudio, Ballesteros, DeAugustine* **Opposed:** *Jacobs* **Abstentions:** *Broadus, Engeran, Marte, Mendia, Ortega, Pierce-Hedge*	**Motion Passes:** 16 ayes, 1 opposed, 6 abstentions
MOTION #7: Approve Comprehensive Care Plan Revision Timeline	***Without objection***	**Motion Passes**
MOTION #8: Approve "CHHS Nominee Evaluation"	***Without objection***	**Motion Passes**
MOTION #9: Approve Commission Co-Chairs strongly assert to DHS that the Commission and PPC need to be involved in the multi-department work group on planning body structure	***Without objection***	**Motion Passes**
MOTION #10: Approve extension of meeting by 15 minutes	***Without objection***	**Motion Passes**
MOTION #11: Approve minute-taking recommendations	**Ayes:** *Broadus, Butler, Eastman, Engeran, Glenn-Rivera, Haupert, Jacobs, Jordan, Lewis, Long, Ma, Marte, Mendia, Palomo, Van Vreede, Younai, Ballesteros, DeAugustine* **Opposed:** *Clavreul, Land,* **Abstentions:** *Aguilar, Bailey, Pierce-Hedge*	**Motion Passes:** 18 ayes, 2 opposed, 3 abstentions
MOTION #12: Approve second extension of meeting by 15 minutes	***Without objection***	**Motion Passes**